# APRIL 1, 2005
# OASIS QUESTIONS & ANSWERS

(Those covered in the Basic Oasis Training on 3/16 & 3/17/05)

## COMPREHENSIVE ASSESSMENT

**Q: May an LPN, OTA, PTA or MSW perform the comprehensive assessment?**

**A:** No. These are clinicians that are not qualified to establish the Medicare home health benefit for Medicare beneficiaries or perform comprehensive assessments.

**Q: What OASIS assessments do I need to complete on my Medicare PPS patients?**

**A:** Comprehensive assessments must be done at start of care (SOC), resumption of care (ROC) following an inpatient (IP) stay of ***24hrs or longer*** (if less than 24hrs no transfer or ROC are necessary), every 60 days and at discharge (DC). When the patient transfers to an IP facility or dies at home, a brief number of OASIS data items must be collected.

**Q: Who can perform the comprehensive assessment in the following incidences?**

**A: -RN & PT are both ordered at SOC?**

*RN*. Either can perform subsequent assessments.

**-PT is ordered at SOC & the RN will enter 7-10 days after SOC?**

*RN* if the RN's entry into the case is ***known*** at SOC, even if for 1 visit. In this example it is not a therapy-only case.

**-PT (or ST) is ordered along with an aide?**

*PT or ST* because this is considered a therapy-only case.

**-Therapy-only case when the agency policy is for the RN to perform an assessment before the therapist's SOC visit?**

The *RN* can do the assessment but it must be either on or within 5 days of the therapist's SOC and the RN **must** do a visit.

**-Both RN & PT will conduct discharge visits on the same day?**

*The last qualified clinician* to see the patient is responsible for conducting the DC comprehensive assessment.

**Q: What if an RN and PT are both ordered at SOC which discipline must conduct the initial assessment?**

**A**: For patients receiving only nursing services or **both nursing and therapy services**, a registered nurse must conduct the initial assessment.

**Q: The SOC (or ROC) assessment is to be done within 48hrs of the referral (or hospital discharge). What do we do if the patient puts us off longer than that?**

**A:** In the absence of a physician ordered SOC date, if the patient refuses a visit within this 48hr period, the agency should contact the physician to see if a delay in visiting would be detrimental to the plan of care. The call should be documented in the chart that the patient refused & the doctor was notified.

**Q: The RN visited a patient for ROC following DC from a hospital. The nurse found the patient in respiratory distress and called 911. There was no opportunity to do the ROC. What should be done?**

**A:** Any partial assessment that was completed can be filed in the record, but HAVEN will not allow a partial assessment. A note explaining the situation should be documented in the chart. Will need to do a ROC when the patient returns home.

**Q: If a patient died before being formally admitted to an inpatient facility, do I collect OASIS for Death at Home? What if the patient is "dead on arrival" in the ER?**

**A:** The patient who dies in the ER is NOT considered to have died while under the care of the agency and therefore is NOT considered a death at home. (This patient would have a transfer assessment completed and any agency required discharge documents.) This is true even though the patient was never formally admitted to the IP facility, because the facility was actively providing care at the time of the patient's death. In contrast, the patient who is pronounced "dead on arrival" by the ER physician on arrival at the ER is considered to have passed away while under the care of the agency and would be considered to have died at home. (This patient would have a "death at home" assessment completed).

**Q: A patient recently returned home from an IP stay. (The transfer OASIS had been completed.) The RN visited to do the ROC but the patient became critically ill & was transferred back to the ER where she died. The ROC was not completed. What OASIS is required?**

**A:** No OASIS needs to be done. The agency had never resumed care of the patient. The agency's discharge summary should be completed to close out the clinical record.

**Q: When a patient is transferred to a hospital, but does not return to the agency, what kind of OASIS assessment is required?**

**A:** No assessment is required. The agency's last contact with the patient was at the point of transfer to the IP facility. The transfer data concludes the episode from the point of OASIS data collection. There would need to be some documentation in the clinical record to close it out for administrative purposes.

**Q: What if the patient refuses to answer OASIS question?**

**A:** The bottom line is **by regulations all OASIS items are required to be completed at specific time points.** First we need to address the patient consent process. Typically, patient consent forms (which must be signed by the patient or their designated representative) include 4 components: a consent to be treated (this would include the comprehensive assessment necessary to develop a plan of care/treatment), a consent for the HHA to bill the pay source, a consent to release patient information to the physician, the patient's insurance or other payer (this would include transmitting the OASIS information to the state as a representative of Medicare/Medicaid) and acknowledgement that the patient has been informed and given written information of his/her rights. The HHA therefore has 2 choices: the patient can either be self -pay or the agency can give free care.

The second issue to address is how are the OASIS items being obtained? The OASIS items should be answered as a result of the clinician's total assessment process. Not straight interview questions. It should encompass both interaction (interview) & observation. The two often complement each other. Many clinicians begin the assessment process with an interview, sequencing the questions in order to build a rapport and gain trust. Others choose to start with the assessment to demonstrate clinical competence before proceeding to the interview.

**Q: Does OASIS data collection have to be initiated on the very first contact in the home?**

**A:** The SOC OASIS items, which must be integrated into your agency's own comprehensive assessment, must be completed in a timely manner, but no later than 5 calendar days after the start of care. The comprehensive assessment is not required to be completed on the initial visit; however, agencies may do so if they choose.

**Q: Does the medication list need to be reviewed by an RN if the patient is a therapy only?**

**A:** In the Conditions of Participation (CoP) under the plan of care requirements it states the comprehensive assessment must include a review of all medications the patient is using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, side effects, drug interactions, duplicate drug therapy and non-compliance. ***This is actually not an OASIS (or CMS) issue, but rather one that depends on your state practice act for therapists.*** In some situations where the practice acts are more restrictive, a lot of the therapists just make a ***list*** of all prescribed medications – then an RN on the agency staff reviews for all the other components of the drug regimen review, which seems to satisfy both the CoP and the state practice acts.

**Q: By what time must the SOC comprehensive assessment be completed?**
**A:** The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later that 5 calendar days ***after*** the start of care. **Start of Care is day "0".**

**Q: What if it takes two days to complete the SOC comprehensive assessment and there was a significant difference in the assessment between the two days – on which day would you base your answers?**

**A:** Combining the answers is not appropriate. If there is a significant difference between the two days base your answers to the OASIS questions on how the patient is the final day of the assessment.

## Follow-up Assessments

**Q: When is a follow-up (f/u) or recertification (recert) assessment due?**

**A:** During the last 5 days of each 60 day period (days 56-60, counting from the SOC date) until discharged. ***You may go in to the OASIS HOME PAGE & print off a calendar to assist you with the counting.***

**Q: What are the requirements for f/u assessment for pediatric and maternity patients where the payer is Medicaid?**

**A:** All pediatric, maternity, and patients receiving only personal care, chore, and housekeeping have been exempt from the OASIS data collection requirements; however, the agency must still perform a comprehensive assessment (without the OASIS items) at any time up to and including day 60. The timetable for the subsequent 60-day period would then be measured from the completion date of the most recently completed assessment. The agency may develop its own comprehensive assessment form for these clients. Clinicians can also conduct the f/u more frequently than the last 5 days of the 60-day episode without having to do another 1 on day 56-60, and remain in compliance with 484.55(d).

**Q: A patient is hospitalized and comes back to the agency on day 56. Which assessment do we complete? A ROC or f/u or both?**

**A:** ***Effective 10/1/04*** the ROC should be completed within 48hrs. Please refer to **OASIS CONSIDERATONS FOR MEDICARE PPS PATIENTS (example #4)** found on the oasis web page at www.cms.hhs.gov/oasis/42304ho6.pdf.

**Q: Should we discharge our patient if a recert was due and we missed the day 55-day 60 time frame?**

**A:** No you should not discharge the patient. At the first possible opportunity you should do the recert OASIS assessment. (It **will** show up as a late assessment on your reports).

**Q: Must both a recert and a ROC be completed when a patient returns to the agency from an IP stay a day or two *before* the last 5 days of a payment episode?**

**A:** In this example, if the patient was discharged on **day 53,** the agency would be required to complete a ROC no later than day 55 and a recert assessment within days 56-60, because the regulations require that the ROC assessment be done within 2 days of the discharge from the IP facility. If the patient were discharged from the IP facility on **day 54 or 55**, the ROC assessment could be done on day 56 or 57, respectively (providing the physician was in agreement). In that case, only a ROC would need to be done.

**Q: Is it necessary to make a visit in order to complete the f/u assessment?**

**A:** Yes, the follow-up comprehensive assessment must be performed in the physical presence of the patient. A telehealth interaction does not constitute an in-person visit for Medicare patients.

**Q: If a clinician's visit schedule is "off track" for a visit in the last 5 days of the 60-day cert period, can a visit be made strictly for the purposes of doing an assessment? Will this visit be reimbursable?**

**A:** A visit can be made for only the purpose of doing the assessment, but it will not be considered a billable visit unless skilled services are performed.

**Q: If a ROC assessment is performed, does the clock "reset" with respect to f/u survey, i.e., is the f/u due 60 days after the ROC or does it remain 60 days from the original SOC date?**

**A:** Unless the patient has been discharged, the due dates for f/u assessments are calculated form the original SOC date rather than from the ROC date.

**Q: Since OASIS is not required for non-Medicare/non-Medicaid pts, must I complete the f/u assessment at day 56-60?**

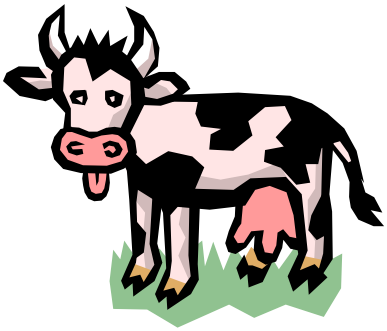
**A:** No. The assessment can be done any time up to and including the 60th day.

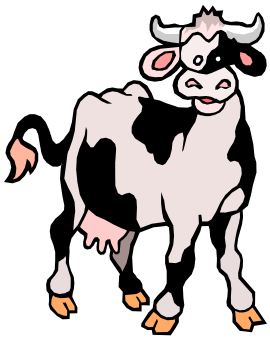
**Q: Does there have to be a physician order for non-billable administrative visits such as HHA supervisory visits or non-billable f/u assessments?**

**A:** If there is a skilled service being done – yes, a doctor order is still needed. For example, a SNV was done to do a blood draw but was unsuccessful in getting the stick. Another nurse must return the next day to do the draw. This is a non-billable visit but would require a physician order to do the skilled service. For HH aide supervisory visits – no, a doctor's order would not be needed.

**Q: A patient is placed on "hold" during an IP stay. While on this " hold" status the patient has subsequent admission to other facilities—hospital, nursing home, and back to hospital again. The agency decides to discharge the patient from service. What OASIS needs to be done?**

**A:** A transfer OASIS would have been done when the patient was transferred to the first hospital. The agency has not resumed care of the patient; therefore, they only need to do a "paper transfer" in the medical record to close the chart out for the agency.





## "MOO" ITEMS

***MOO10 -Agency Medicare Provider Number***
***MOO12 –Agency Medicaid Provider Number***

**Q: Do we have to fill out MOO10 & MOO12 if the patient isn't Medicaid or Medicare?**

**A:** Yes, these provider numbers must be included on all patient assessment data being transmitted to the state. The agency Medicare and Medicaid provider numbers are used as identifiers of the agency submitting the data and are used to help keep individual patient information accurately linked with that same patient throughout the episode of care.

***MOO16 –Branch ID Number***

**Q: What do we enter in MOO16 Branch ID if I am a HHA with no branches, a parent, a subunit, or a branch?**

**A:** If you are a HHA with no branches, enter "N" followed by 9 spaces. If you are a parent HHA that has branches, enter "P" followed by 9 spaces. If you are a subunit with no branches, enter "P" followed by 9 spaces. If you are a branch, enter the Branch ID number assigned by the Regional Office. The Branch identifier consists of 10 digits- - the State code as the first two digits, followed by Q (upper case), followed by the last four digits of the current Medicare provider number, ending with the 3-digit CMS assigned branch number. **(Refer to page 8/16 in Chapter 9 of the OASIS Implementation Manual).**

*MOO30 –Start of Care Date*

**Q: Does the SOC date at MOO30 always stay the same no matter how many recertifications?**

**A:** The SOC date (MOO30) is the date when the patient was first admitted to the agency and continues until the patient is discharged. It should correspond to the SOC date used for other documentation, such as billing or physician orders.

**Q: What if a new service enters the case during the episode? Does it have a different SOC date?**

**A:** There is only one SOC date for the episode, which is the date of the first billable visit.

*MOO32-Resumption of Care Date*

**Q: What if the latest ROC was in a previous 60-day episode/certification period?**

**A:** The most recent ROC should be documented, even if it was in a previous 60-day payment episode, as long as the patient has not been discharged from the agency since the most recent ROC.

*MOO50 – Patient State of Residence*

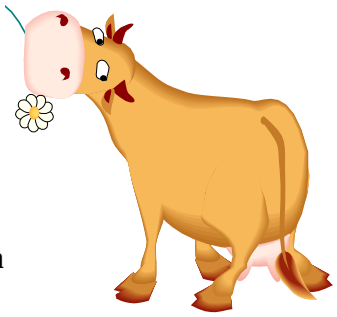
**Q: In MOO50 if the patient is actually from Tennessee but is staying with family in Missouri, which State is entered?**

**A:** The state in which the patient is currently residing while receiving home care is the state that you enter.

*MOO63 -Medicare Number*
*MOO65 –Medicaid Number*

**Q: In MOO63 & MOO65 if the patient has Medicare/Medicaid but it is not the primary pay source for this given period, should the patient's Medicare/Medicaid number be entered?**

**A:** The patient's Medicare/Medicaid number should be entered, whether or not Medicare/Medicaid is the pay source for the episode. Keep in mind that Medicare/Medicaid are often secondary payers, even when another payer will be billed first. In order to bill them as secondary, the patient must be identified as a Medicare/Medicaid patient from the SOC.



*MOO72 – Primary Referring Physician ID*

**Q: At MOO72, what if the referring physician and the primary physician responsible for care are different?**

**A:** The one who signs the 485 is the physician responsible for the patient's care.

*MOO90 –Date Assessment Completed*

**Q: We have 5 calendar days to complete the admission/SOC assessment. What date do we list on OASIS for MOO90 when information is gathered on days one, three, & five?**

**A:** You would enter the last day that the assessment information was obtained on the patient in his/her home, if all clinical data items were completed. However, if the clinician needs to f/u, off-site, with the patient's family or physician in order to complete a clinical data item, MOO90 should reflect that date. (This should be a rare incidence).

**Q: Is the date that an assessment is completed, in MOO90, required to coincide with the date of a home visit? When must the date in MOO90 coincide with the date of a home visit?**

**A:** SOC, ROC, f/u and discharge assessments (RFA 1,3,4.5,and 9 for MO100) must be completed through an in-person contact with the patient (home visit). The transfer or death at home assessments (RFA 6,7,or 8 for MO100) will have the date the agency learns of the event recorded at MOO90.

**Q: Do the dates in MOO90 and MO903 (date of last home visit) always need to be the same? What situations might cause them to differ?**

**A:** When a patient is discharged from the agency with goals met, the date of the assessment (MOO90) and the date of the last home visit (MO903) is likely to be the same. **Under 3 situations these dates are likely to be different: (1) transfer to an IP facility; (2) patient death at home, and (3) the situation of an unexpected discharge.** In these situations, **the MOO90 date is the date the agency learns of the event**, which is not necessarily associated with a home visit.

**Q: After Oasis data are collected and completed by the qualified clinician as part of the comprehensive assessment, how long does the agency have before they must encode the data?**

**A**: The HHAs may take up to seven calendar days after the date of completion of the comprehensive assessment (MOO90) to enter (encode) the OASIS data into their computer software. The day the clinician completes the assessment is day zero for purposes of calculating the 7-day window.

***MO100 – This Assessment is Currently Being Completed for the Following Reason:***

***<u>Start/Resumption of Care</u>***

***1 – Start of care – further visits planned***

***3 – Resumption of care (after inpatient stay)***

***<u>Follow-Up</u>***

***4 – Recertification (f/u) reassessment***

***5 – Other follow-up***

***<u>Transfer to an Inpatient Facility</u>***

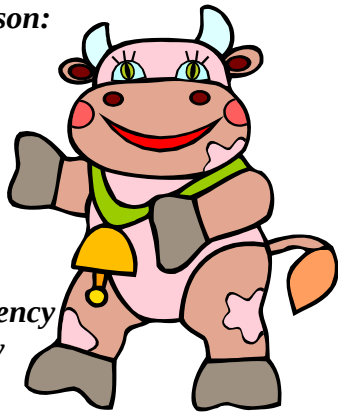
***6 – Transferred to an IP facility – patient not discharged from agency***

***7 – Transferred to an IP facility – patient discharged from agency***

***<u>Discharge from Agency –Not to an Inpatient Facility</u>***

***8 – Death at home***

***9 – Discharge from agency***



**Q: Does "transfer" mean 'transfer to another non-acute setting' or 'transfer to an inpatient facility?**

**A:** Transfer means transfer to an IP facility, i.e., a hospital, rehab facility, Nursing home or inpatient hospice for 24hr or more.

**Q: Which Reason for Assessment (RFA) should be used when a patient is transferred to another agency?**

**A:** Patient must be discharged using RFA 9 to enable the new agency to bill for the patient's care.

**Q: For a one visit Medicare patient, is RFA 1 the appropriate response for MO100? Is the data entered? Is it transmitted? Is a discharge OASIS completed?**

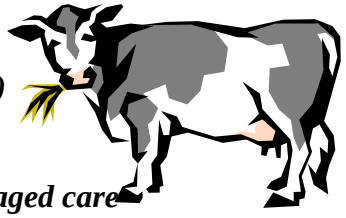
**A:** RFA 1 is the appropriate response on MO100. The OASIS data should be encoded to generate a HIPPS code and transmitted to the State system. No discharge assessment is required as the patient only received one visit. The agency clinical documentation should note that no further visits occurred. Now, if the patient were admitted again to the agency (within 6 months because the patient's name will remain in the data management system that long before it will be dropped off) and a SOC is done, the agency would receive a warning that the new assessment was out of sequence but it would not prevent the agency from transmitting the assessment anyway.

**Q: Do we discharge a Medicare client who is in the hospital beyond the 60-day period?**

**A:** The HHA should discharge a Medicare patient who remains in the hospital beyond day 60 of a PPS payment episode. If the transfer OASIS assessment was completed on admit to the hospital, no further OASIS assessments are needed.

**Q: When a patient is transferred to a hospital, but does not return to the agency, what kind of OASIS is required?**

**A:** No assessment is required at this point. The agency's last contact with the patient was at the point of transfer to the IP facility, so the transfer data conclude the episode from the point of OASIS data collection. The HHA would want to do some type of discharge documentation in the clinical record to close it for administrative purposes.



***MO150 – Current Payment Sources for Home Care (mark all that apply)***

| | |
|---|---|
| ***0-None; no charge*** | ***7-Other government*** |
| ***1-Medicare (traditional fee-for-service)*** | ***8-Private Insurance*** |
| ***2-Medicare (HMO/managed care)*** | ***9-Private HMO/managed care*** |
| ***3-Medicaid (traditional fee-for-service)*** | ***10-Self-pay*** |
| ***4-Medicaid (HMO/managed care)*** | ***11-Other*** |
| ***5-Worker's compensation*** | ***12-Unknown*** |
| ***6-Title programs*** | |

**Q: For MO150, what should be the response if the clinician knows that a patient has health insurance but that the insurance typically won't pay until attempts have been made to collect from the liability insurance (e.g., for injuries due to an auto accident or a fall in a public place)?**

**A:** The purpose of the data item is to identify the current payer(s) for the home care episode. Note that it asks for **"current payment sources"…"mark all that apply**". At admission the clinician should mark all coverage available. The item is **NOT** restricted to the primary payer source.

**Q: The patient's payer source changes from a pay source to Medicare or vice versa. How is the OASIS handled then?**

**A:** ***If the pay source required OASIS transmission*** (Medicaid) they would discharge the patient on the last day of the old pay source using the OASIS discharge *(the last visit being billed to the pay source)* and re-assessed under the new pay source with a new SOC comprehensive assessment. (This includes doing a new 485 so the OASIS & the new SOC date coincide.) They would then complete a new OASIS SOC based on the new SOC date. (The 1st billable visit after eligibility). ***If the pay source did not require OASIS*** (private insurance) then only an agency (paper) discharge is necessary since there is nothing in the system. The schedule for the comprehensive assessment and updates continues based on the original SOC date. The HHA simply indicates that the pay source has changed at MO150.

**Q: Which pay sources should be noted when responding to MO150?**

**A:** All current pay sources regardless of whether the pay source is primary or secondary.

**Q: Does this mean that when Medicare is a secondary payer, Medicare (response 1) should be checked?**

**A:** Yes. If Medicare and other pay sources are paying for care provided by a single agency, **all** the relevant pay sources should be noted.

**Q: What if the patient has two pay sources (potential), but the care for this episode is only being billed to one?**

**A:** Only the current pay source should be marked.

**Q: What if the patient became Medicare/Medicaid after the fact?**

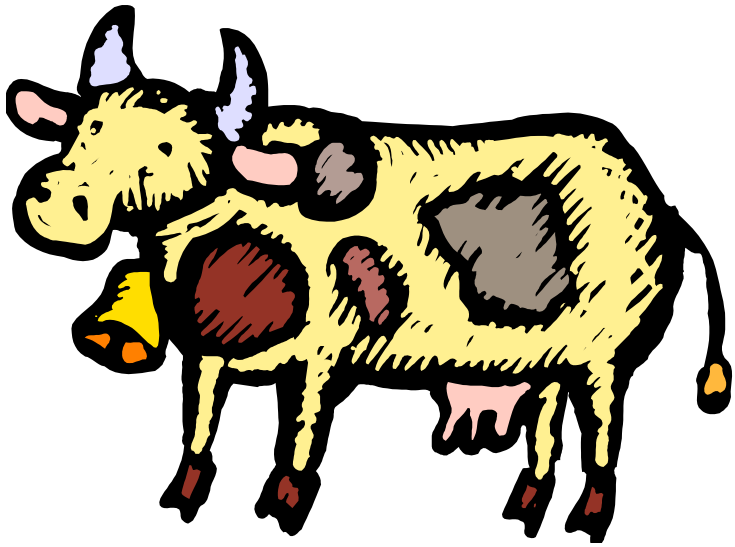
**A:** If the HHA wants to be paid they will need to provide the OASIS data. The agency should contact the RHHI if it's a Medicare patient and the RHHI will direct them on how to handle that (in essence, they will need to submit at least the items required for payment). If it's Medicaid, they will need to "recreate" the assessment data from their clinical records (assuming that comprehensive assessments were done on schedule) and submit to the state. They will get a warning message about not meeting the timing requirements, but it will not prevent transmitting the data. The agency needs to document in the patient's clinical record exactly what happened just in case someone decides to inquire about the situation. .

**Q: Is this MOO item limited to payment for home care services? If a patient had out-of-pocket expenses for DME or for prescription or over-the-counter meds, should response "self-pay" be marked?**

**A:** Yes, this item is limited to payment for home care services. If equipment or medications essential and/or **integral to the home care episode** are being paid for, in part or full, by the patient, then response 10- self pay should be marked.

**Q: If a patient is Medicaid –pending do we mark "#3 Medicaid" in MO150?**

A: In MO150 you must EXCLUDE any "pending" payment sources. Therefore, you would NOT mark #3 Medicaid.



***MO175 –From which of the following Inpatient Facilities was the patient discharged during the past 14 days? (Mark all that apply)***

***1-Hospital***
***2-Rehabilitation facility***
***3-Skilled nursing facility***
***4-Other nursing home***
***5-Other***
***6-NA***

***MO180 –Inpatient Discharge Date***

***Month/day/year***
***UK – unknown***

**Q: If the patient has an outpatient (OP) surgery within the 14-day time frame, should #1 or NA be marked in MO175?**

**A:** NA

**Q: What is the difference between response 3 (skilled nursing facility 'SNF') and response 4 (other nursing home) in MO175?**

**A:** A SNF means a Medicare-certified nursing facility where the patient received a skilled level of care under Medicare Part A benefit. Other nursing facility includes intermediate care facilities for the mentally retarded (ICF/MR) and regular nursing facilities (NF).

**Q: Please define 14 days.**

**A:** The "past 14 days" encompasses the two-week period immediately preceding the SOC/ROC or the first day of the new certification period. (The SOC/ROC date is day zero).

**Q: What if the patient has been discharged from more than one facility in the past 14 days? How do we mark MO180?**

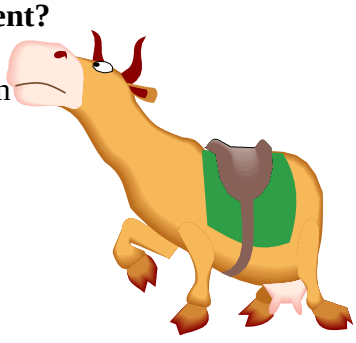
**A:** Use the most recent date of discharge from any IP facility.

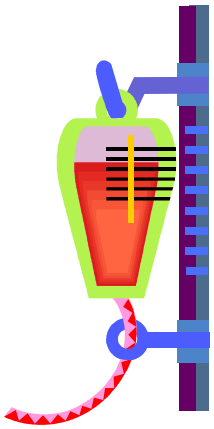
***MO250 –Therapies the patient receives at home. (Mark all that apply.)***

***1-Intravenous or infusion therapy (excludes TPN)***
***2-Parenteral nutrition (TPN or Lipids)***
***3-Enteral nutrition (NG, gastrostomy, jejunostomy, etc)***
***4-None of the above***

**Q: If the discharge visit includes discontinuing IV or infusion therapy should MO250 reflect the presence of those services on the discharge assessment?**

**A**: Yes, if the IV is being discontinued the day of the assessment visit, then those respective services can be marked as "present" at the assessment.





**Q: Does MO250 refer to the therapies the patient is receiving when the staff member walks in to do the assessment? Clarify.**

**A:** MO250 refers to therapies the patient is receiving at the time of the assessment visit or which the patient is ordered to receive as a result of the assessment visit.

**Q: Does an IM or SQ injection given over a ten- minute period count as an infusion?**

**A:** No, this injection does not qualify as infusion therapy.

**Q: If the caregiver provides the enteral nutrition should response 3 be marked?**

**A:** MO250 simply asks about therapies the patient is receiving at home. Since this patient is receiving enteral nutrition at home response 3 should be marked.

**Q: If the patient refuses tube feedings, does this qualify as enteral nutrition?**

**A:** Because the patient is not currently receiving enteral nutrition, response 3 would not be appropriate at the time of the assessment. The refusal of the tube feeding would be noted in the clinical record. ***Flushing*** the tube does ***not*** provide nutrition.

**Q: If the patient has an IV catheter present but only doing dressing changes do we mark #1?**

**A:** If the IV catheter is not being used & only dressing changes are being done you do NOT mark #1. But if you are ***flushing*** the IV for patency, you would mark #1.

**Q: What if a patient has a port that is being used for monthly chemotherapy that is being given in the physician's office and the HHA nurse isn't even flushing the port.**

**A:** The answer would be "no" because the infusion is not being given in the home. This question is about infusion **at home**.

***MO390 –Vision with corrective lenses if the patient usually wears them:***

***0-Normal vision: sees adequately in most situations***

***1-Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; <u>can</u> count fingers at arm's length***

***2-Severely impaired: cannot locate objects without hearing or touching them <u>or</u> patient nonresponsive.***

**Q: Is a magnifying glass considered a corrective lens? How about reading glasses?**

**A:** A magnifying glass is not a corrective lens; reading glasses are considered corrective lenses.

***MO420 –Frequency of Pain interfering with patient's activity or movement:***

***0-Patient has no pain or pain does not interfere with activity or movement***

***1-Less often than daily***

***2-Daily, but not constantly***

***3-All of the time***

***MO430- Intractable Pain: Is the patient experiencing pain that is not easily relieved, occurs at least daily, and affects the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity?***

***0-No***

***1-Yes***

**Q: When scoring MO420 does the pain have to prevent the activity or just alter or affect the frequency/method of the activity?**

**A:** For pain to interfere with activity, it does not have to totally prevent the activity. It can cause the activity to take longer to complete, result in the activity being performed less often then otherwise desired by the patient or requires the patient to have additional assistance.

**Q: If a patient uses a cane for ambulation in order to relieve low back pain, does the use of the cane equate to the pain interfering with activity?**

**A:** Assuming use of the cane provides adequate pain relief to allow the patient to ambulate in a manner that does not significantly affect distance or performance of other tasks, then the cane should be considered a "non-pharmacological" approach to pain management, and should not, in and of itself, be considered as an "interference" to the patient's activity. If however, the use of the cane does not fully alleviate the pain, and even with the use of the cane the patient limits ambulation, or requires additional assist with gait activities, then such events would be considered as "affected" or "interfered with" by pain, and the frequency of such activities should be included when scoring MO420.

**Q: Would a patient who restricts his/her activity to be pain-free be considered to have pain interfering with activity? If so, would the score be based on the frequency that the patient limits or restricts the activity in order to remain pain-free?**

**A:** Yes, a patient who restricts his/her activity to be pain-free does have pain interfering with activity. Since MO420 reports the frequency that pain interferes with activity, and not the presence of pain itself, then even if this patient is pain-free, MO420 should be scored to reflect the ***frequency*** that the patient's activities are affected or limited by pain (either actual experienced pain, or the anticipation of pain that is expected by the patient, if the restricted activity were to occur.)

**Q: How do I know the patient's pain is intractable?**

**A:** Intractable pain is pain that is not easily relieved with treatment and occurs at least daily. Intractable pain refers not only to cancer pain, but also to pain that is ever present, which may affect the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions or ability or desire to perform physical activities.

**Q: In order for the pain to be considered "intractable" does all the components have to be met?**

**A:** Yes, in order to be considered intractable pain all 3 components must be met. It must: not be easily relieved, occurs at least daily, and affects the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity?

***MO440- Does this patient have a Skin Lesion or an Open Wound? (This excludes "OSTOMIES."***

***0-No 1-Yes***

**Q: Do all scars qualify as skin lesions?**

**A:** Yes, a scar meets the definition of an area of pathologically altered tissue.

**Q: How many different types of skin lesions are there?**

**A:** There are many different types of skin lesions. **Primary:** (arising from previously normal skin) vesicles, pustules, wheals or **Secondary**: (resulting from changes in primary lesions) crusts, ulcers, or scars. **Changes in color or texture:** macerations, scaling. **Changes in shape of the skin surface**: cyst, nodule, edema. **Breaks in skin surface**: abrasion, excoriation, fissure, incision. **Vascular lesions**: petechiae, ecchymosis.

**Q: If the patient has a porta- cath, but the agency is not providing any services related to the catheter and not accessing it, would this be coded as a skin lesion?**

**A:** For MO440 you would answer *YES* for a lesion. The presence of a wound or lesion should be documented regardless of whether the home care agency is providing services related to the wound or lesion.

**Q: Is a *new* ostomy considered an open wound?**

**A:** NO. Ostomies are to be EXCLUDED from consideration as open wounds or skin lesions.

**Q: What about implanted infusion devices or venous access devices?**

**A:** Yes. These devices are considered wounds at MO440.

**Q: Are diabetic foot ulcers classified as pressure ulcers, stasis ulcers, or simply as wound/lesions at MO440 and MO445?**

**A**: The physician must make the determination as to whether a specific lesion is a diabetic ulcer, a pressure ulcer, stasis ulcer, or other lesion. In responding to the OASIS, and ulcer diagnosed by the doctor as a diabetic ulcer would be considered a lesion, ("yes" to MO440) but it would not be considered a pressure ulcer or a stasis ulcer.

**Q: Is a pacemaker considered a skin lesion?**

**A:** YES. The (current) surgical wound or (healed) scar created when the pacemaker was implanted is considered a skin lesion.

**Q: How should MO440 be answered if the wound is not observable?**

**A:** For the OASIS items, a "non-observable" wound is one that is covered by a non-removable dressing, or (in the case of pressure ulcers, an ulcer that is partially or entirely covered by eschar). If you know from referral information, communication with the physician, etc., that a wound exists under a non-removable dressing, then the wound is considered to be present, and MO440 would be answered "yes".

**Q: What about a burn?**

**A:** MO440 should be answered "yes", since a lesion is present. Additional documentation that describes the burn should be included in the clinical record, but burns are not addressed in the OASIS items.

**Q: Is a gastrostomy that is being allowed to close on its own considered a surgical wound?**

**A:** A gastr**ostomy** that is being allowed to close would be excluded from consideration as a wound or lesion (MO440). However, the "take-down" of an ostomy that was done as a **surgical** procedure would result in both an open wound ("yes" to MO440), and a surgical wound ("yes" to MO482).

**Q: How should the items be marked when the patient's surgical wound is healed?**

**A:** If healed completely it is no longer considered a current surgical wound. The resulting scar would be noted as a "yes" response to MO440, but MO482 would be marked "no".

***MO445- Does this patient have a Pressure Ulcer?***

***0-No***

***1-yes***

***MO450- Current Number of Pressure Ulcers at Each Stage (circle one response for each stage)***

***(a) <u>Stage 1</u>-Nonblanchable erythema of intact skin; the heralding of skin ulceration. In darker-pigmented skin, warmth, edema, hardness, or discolored skin may be indicators.***

***(b)<u>Stage 2</u>-Partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.***

***(c)<u>Stage 3-</u> Full-thickness skin loss involving damage or necrosis of subcutaneous tissue which may extend down to, but not through, underling fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.***

***(d)<u>Stage 4</u>- Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures***

***(e)In addition to the above, is there at least one pressure ulcer that cannot be observed due to the presence of eschar or a nonremovable dressing, including casts?***

***0-No 1-Yes***

***MO460-Stage of Most Problematic (Observable) Pressure Ulcer:***

***1-Stage 1 4-Stage 4***

***2-Stage 2 NA-No observable pressure ulcer***

***3-Stage 3***

***MO464-Status of Most Problematic (Observable) Pressure Ulcer:***

***1-Fully granulating 3-Not healing***

***2-Early/partial- granulation NA-No observable pressure ulcer***

**Q: Are healed pressure ulcers recorded as pressure ulcers?**

**A:** The answer to this question varies depending on what stage the pressure ulcer in question is. Please refer to www.cms.hhs.gov/oasis/npuap.pdf .

**Q: If a patient has a pressure ulcer or a stasis ulcer and receives a skin graft in the hospital, how is this recorded on the ROC at MO440?**

**A:** The skin graft is a treatment approach to an underlying problem, that of the pressure or stasis ulcer. Therefore, the original pressure ulcer or stasis ulcer remains, now being treated by a skin graft. Note that if the patient is the donor for the skin graft, then the donor site is a new lesion (MO440) that has been created by a surgical procedure, so it would be considered a surgical wound. (MO482)

**Q: Are diabetic foot ulcers classified as pressure ulcers, stasis ulcers or simply as wound/lesions at MO440 & MO445?**

**A:** If the foot ulcer results from prolonged pressure, it is a pressure ulcer. If it is caused by inadequate venous circulation in the area, then it is a stasis ulcer. If neither of these is true, then the foot ulcer is regarded as a lesion. Verify the type of ulcer with the patient's doctor to be sure it is categorized appropriately.

**Q: If a Stage 3 pressure ulcer is closed with a muscle flap, what is recorded? What if the muscle flap begins to break down due to pressure?**

**A:** If a pressure ulcer is closed with a muscle flap the new tissue completely ***replaces*** the pressure ulcer. In this scenario, the pressure ulcer "goes away" and is replaced by a surgical wound. If the muscle flap healed and then begins to break down due to pressure, it would be considered a new pressure ulcer. If the flap had never healed it would be a non-healing surgical wound.

**Q: At MO450, should we document a pressure ulcer whose stage worsens?**

**A:** ABSOLUTELY. If a pressure ulcer worsens in stage (or if its status worsens), this information should be noted in MO450 through MO464.

**Q: Should a pressure ulcer that was clearly documented as stage 4 prior to a hospitalization but is covered with eschar upon return be classified as Stage 4?**

**A:** The bed of the ulcer must be visible to accurately determine the stage. If there is necrotic tissue, it cannot be staged until the necrotic tissue is removed. The assessment should reflect the status of the wound on the day of the assessment and not prior to the hospitalization. Therefore, will need to be documented as "non-observable". In this case though, the necrotic tissue indicates a non-healing wound, so when the eschar is removed the agency can perform a SCIC (significant change in condition) assessment to determine the accurate stage and move forward with the treatment plan from there.

**Q: If a wound is surgically debrided how would we respond to MO450?**

**A:** If the pressure ulcer is only surgically debrided it remains a pressure ulcer.

**Q: If a pressure ulcer is covered by eschar can it be staged?**

**A:** In MO450, a pressure ulcer covered by eschar, slough or a dressing or cast cannot be staged. The bed of the ulcer must be visible to stage.

**Q: In MO464 please give examples of "not healing"**

**A:** A stage 1 pressure ulcer, an infected pressure ulcer, a pressure ulcer partially covered or covered by necrotic tissue or eschar are "not healing" pressure ulcers.

**Q: How can one OASIS tell whether a pressure ulcer has improved?**

**A:** The OASIS items are used for outcome measurement and risk factor adjustment. There are NO outcome measures computed for pressure ulcer improvement. (There should be descriptive documentation in the patient's clinical record addressing changes in pressure ulcer size and status that show improvement.)

***MO468 –Does this patient have a Stasis Ulcer?***
***0-No***
***1-Yes***
***MO470 –Current Number of Observable Stasis Ulcers***
***0-Zero*** ***3-Three***
***1-One*** ***4-Four or more***
***2-Two***
***MO474 –Does this patient have at least one Stasis Ulcer that Cannot be Observed due to the presence of a non-removable dressing?***
***0-No***
***1-Yes***
***MO476 –Status of Most Problematic (Observable) Stasis Ulcer:***
***1-Fully granulating*** ***3-Not healing***
***2-Early/partial-granulation*** ***4-NA-No observable stasis ulcer***

**Q: How can I determine whether the patient's ulcer is a stasis ulcer or not?**

**A:** The physician is the best information source regarding the root cause of the ulcer. (There's a WOCN web site **http://www.wocn.org** that has clinical fact sheets regarding the assessment of leg ulcers, information on arterial insufficiency, and information on venous insufficiency (stasis).)

*MO482 –Does this patient have a Surgical Wound?*

*0-No*

*1-Yes*

*MO484 –Current Number of (Observable) Surgical Wounds*

*0-Zero* *3-Three*

*1-One* *4-Four or more*

*2-Two*

*MO486 –Does this patient have at least one Surgical Wound that Cannot be Observed due to the presence of a non-removable dressing?*

*0-No*

*1-Yes*

*MO488 –Status of Most Problematic (Observable) Surgical Wound:*

*1-Fully granulating* *3-Not healing*

*2-Early/partial granulation* *4-NA-No observable surgical wound*

**Q: If a wound is partially closed but has more than one opening, is each opening considered a separate wound?**
**A:** Yes

**Q: Are suture or staple insertion sites considered to be separate wounds**?
**A:** No

**Q: When would a surgical wound no longer be reported as a surgical wound in MO482?**

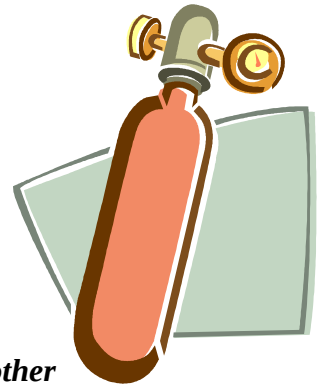
**A:** A wound no longer qualifies as a surgical wound when it is completely healed (thus becoming a scar). (Follow the Wound, Ostomy, and Continence Nurses' guidelines (OASIS Guidance Document) found at **http://www.wocn.org** to determine when healing has occurred. CMS does not follow time intervals in determining when a wound has healed, since the healing status of the wound can only be determined by a skilled assessment and the time for healing varies widely between patients.

**Q: Are implantable infusion devices or venous access devices considered surgical wounds? Are they included in the "count" even if they are not accessed?**

**A:** Yes, the surgical sites where such devices were implanted would be considered surgical wounds and included in the total number of surgical wounds at MO484. It does not matter whether the device is accessed at a particular frequency or not.

**Q: Is a mediport "non-observable" because it is under the skin?"**

**A:** Non-observable is an appropriate response ONLY when a non-removable dressing is present. As long as the mediport is present, whether it is being accessed or not, the patient is considered as having a current surgical wound.



*MO490 –When is the patient dyspneic or noticeably Short of Breath?*

*0-Never, patient is not short of breath*
*1-When walking more than 20 feet, climbing stairs*
*2-With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)*
*3-With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation*
*4-At rest (during day or night)*

**Q: What if my patient normally uses oxygen?**

**A:** If the patient usually uses oxygen, mark what best describes the patient's shortness of breath while using the oxygen. If patient uses oxygen intermittently, mark what best describes the patient's shortness of breath **without** the oxygen.

**Q: How should I best evaluate dyspnea for a chair-fast or bed-bound patient?**

**A: You would evaluate the patient that is chair-fast or bed-bound just as you would a patient that was able to get up and around. The chair-fast patient can be assessed for level of shortness of breath while performing ADLs or at rest. If the patient does not have any shortness of breath with moderate exertion, then either response 0 or response 1 is appropriate. If the patient is never short of breath, then response 0 applies. If the patient only becomes short of breath when engaging in physically demanding transfer activities then response 1 seems more appropriate. Same done for the bed-fast patient.**

*MO520 –Urinary Incontinence or Urinary Catheter Presence:*

*0-No incontinence or catheter (includes anuria or ostomy for urinary drainage)*
*1-Patient is incontinent*
*3-Patent requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic)*

*MO530 –When does Urinary Incontinence occur?*

*0-Timed-voiding defers incontinence*
*1-During the night only*
*2-During the day and night*

**Q: Is the patient incontinent if she only has stress incontinence when coughing?**

**A:** Yes, the patient is incontinent if incontinence occurs under any situation. This includes "dribbling".

**Q: If a patient has a urostomy or ureterostomy what should be marked in MO520?**
**A:** A urostomy or ureterostomy is considered an ostomy for urinary drainage. The appropriate response therefore, is "0-no incontinence or catheter"

**Q: If the patient has stress incontinence during the day that is not deferred by timed-voiding, how would MO530 be answered?**

**A:** Response 2 at MO530 is the only response that includes the time period of 'day'. Therefore, this response is the appropriate one to mark.

***MO540 –Bowel Incontinence Frequency:***

***0-very rarely or never***
***1-Less than once weekly***
***2-One to three times weekly***
***3-Four to six times weekly***
***4-On a daily basis***
***5-More often than once daily***
***NA-Patient has ostomy for elimination***
***UK-Unknown***

***MO550 –Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay; <u>or</u> b) necessitated a change in medical or treatment regimen?***

**Q: If I have a patient whose ostomy has been reversed how would I answer these MOO items?**

**A:** If an ostomy has been reversed, then the patient does not have an ostomy at the time of assessment.

**Q: How should you respond to MO540 if the patient is on a bowel-training program? How is this documented in the clinical record?**

**A:** A patient on a regular bowel evacuation program most typically is on that program as an intervention for fecal impaction. Such a patient may additionally have occurrences of bowel incontinence, but there is no assumed presence of bowel incontinence simply because a patient is on a regular bowel program. The bowel program, including the overall approach, specific procedures, time intervals, etc. should be documented in the patient's clinical record.

**Q: If a patient with an ostomy was hospitalized with diarrhea in the past 14 days, does one mark response 2 to MO550?**

**A:** Response #2 is the appropriate response in this situation. By description of the purpose of the hospitalization, the ostomy was related to the inpatient stay.

**Q: For MO540 what if the patient has a colostomy but also has bowel incontinence (i.e., has a fistula)?**

**A:** The answer would be "NA" because the patient has an ostomy.

***MO610 – Behaviors Demonstrated at Least Once a Week (Reported or or Observed) (Mark all that apply)***

***1-Memory deficit***
***2-Impaired decision-making***
***3-Verbal disruption***
***4-Physical aggression***
***5-Disruptive, infantile, or socially inappropriate behavior***
***6-Delusional,hallucinatory, or paranoia***
***7-None of the above behaviors***

***MO620 –Frequency of Behavior Problems (Reported or Observed) (e.g., wandering episodes, self abuse, verbal disruption, physical aggression, etc.):***

***0-Never***
***1-Less than once a month***
***2-Once a month***
***3-Several times each month***
***4-Several times a week***
***5-At least daily***

***MO630 –Is this patient receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse?***

***0-No***
***1-Yes***

**Q: Are the behavior problems in MO620 limited to only those identified in MO610?**

A: No. The behavior problems in MO630 are not limited to only those identified in MO610. It is any behavior of concern for the patient's safety or social environment.

***MO640- Grooming: Ability to tend to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make-up, teeth or denture care, fingernail care) (Asks for current status and prior status)***

***0-Able to groom self unaided, with or without the use of assistive devices or adapted methods.***
***1-Grooming utensils must be placed within reach before able to complete grooming activities.***
***2-Someone must assist the patient to groom self.***
***3-Patient depends entirely upon someone else for grooming***
***UK - Unknown***

**Q: Must I see the patient comb his/her hair or brush his/her teeth in order to respond to this item?**

**A:** No, as the assessment of the patient's coordination, manual dexterity, upper-extremity range of motion (hand to head, hand to mouth, etc.), and cognitive/emotional status will allow the clinician to evaluate the patient's ability to perform grooming activities.

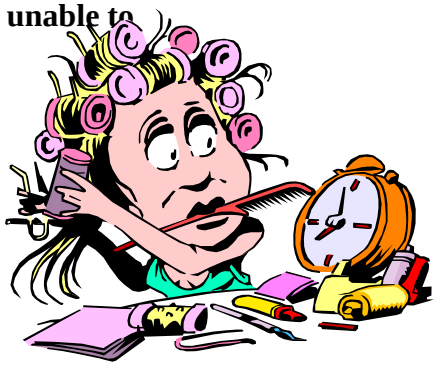
**Q: Is toileting hygiene part of this item?**

**A:** The term "toileting hygiene" typically is used to refer to the activities of managing clothing before and after elimination and of wiping oneself after elimination. If these are the activities implied by this question, the response is "no, toileting hygiene is not part of this item". If the question refers to the patient's ability to wash his/her hands, this activity is considered part of grooming.

**Q: If the patient is able to perform the grooming tasks but is not compliant how do you answer the oasis question?**

**A:** The items are completed according to the patient's **ABILITY,** not actual performance. "Willingness" & "compliance" are not the focus of any of the functional status items.

**Q: What if my patient was able to do most of his/her grooming the day before but on the day of my assessment he/she was having a "bad" day & was unable to perform the activities as well?**



**A:** In any of the functional items, you must consider what the patient is *able to do* on the *day of* the assessment. If it varies on that day, choose the response that describes the patient's ability > 50% of the time.

**Q: What is meant by the "prior" column?**

**A:** The "prior" column corresponds to the patient's condition 14 days prior to the assessment day. 14 days *"**prior to**"* means what was the patient's status ***on that 14th*** *day*. When answering "*within 14 days*" consider the *entire* 14-day period. It is very important to adhere *rigidly* to the 14 days.

**Q: What if on that 14th day prior to the patient was admitted to the hospital for same day surgery – would you answer how the patient was prior to the surgery or p after the surgery?**

**A:** Record what the patient's status was prior to the surgery.

**Q: Does this OASIS item include bathing?**

**A:** This item EXCLUDES bathing.

**Q: What if my patient can do most of his/her grooming tasks but requires some cueing?**

**A:** Response 2 –" Someone must assist the patient to groom self" – includes standby assistance or verbal cueing.

***MO650 –Ability to Dress Upper Body (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:***

***0-Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.***

***1-Able to dress upper body without assistance if clothing is laid out or handed to the patient.***

***2-Someone must help the patient put on upper body clothing.***

***3-Patient depends entirely upon another person to dress the upper body.***

***MO660 –Ability to Dress Lower Body (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:***

***0-Able to obtain, put on, and remove clothing and shoes without assist***

***1-Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.***

***2-Someone must help the patient put on garments, slacks, socks or nylons and shoes.***

***3-Patient depends entirely upon another person to dress lower body.***

**Q: What if my patient requires standby assistance to dress?**

**A:** If the patient requires standby assistance (a "spotter") to dress **safely** or requires cueing/reminders than response 2 – "Someone must help the patient put on garments…." applies.

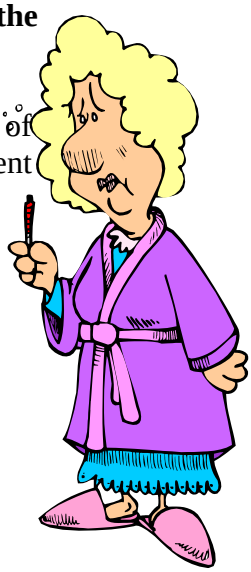
**Q: What if my patient has a prosthesis?**

**A**: If a patient must apply a lower or upper-extremity prosthesis, this prosthesis should be considered as part of the body apparel.

**Q: If my patient uses a sock aid to put on his/her socks how would I answer this item?**

**A:** If a patient utilizes a sock aid, buttonhook, etc and because of these devices is independent then use response "0"

**Q: If the patient is wearing a housecoat, should I evaluate her ability to dress in the housecoat or in another style of clothing?**



**A:** The appropriate response should indicate the patient's ability to dress (or the level of assistance needed to dress) in whatever clothing she would routinely wear. If the patient routinely wears another style of clothing, the assessment should include the skills necessary to manage zippers, buttons, hooks, etc. associated with this clothing style.

**Q: What if the patient must dress in stages due to shortness of breath?**
**A:** If the patient is able to dress herself/himself independently, this is the response that should be marked, even if the activities are done in steps. If the dressing activity occurs in stages because verbal cueing or reminders are necessary for the patient to be able to complete the task, then response 2 is appropriate. **(Note that the shortness of breath would be addressed in MO490)**

***MO670 –Bathing: Ability to wash entire body. <u>Excludes</u> grooming (washing face and hands only)***

***0-Able to bathe self in <u>shower or tub</u> independently***
***1-With the use of devices, is able to bathe self in shower or tub independently.***
***2-Able to bathe in shower or tub with the assistance of another person: a) for intermittent supervision or encouragement or reminders, <u>OR</u> b) to get in and out of the shower or tub, <u>OR</u> c) for washing difficult to reach areas.***
***3- Participates in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.***
***4-Unable to use the shower or tub and is bathed in <u>bed or bedside chair.</u>***
***5-Unable to effectively participate in bathing and totally bathed by another person.***

**Q: For MO670, should the clinician consider the patient's ability to perform bathing related tasks, like gathering supplies, preparing the bath water, shampooing hair or drying off after the bath?**

**A:** When scoring MO670, only the patient's ability to "wash the entire body" should be considered. Bathing-related tasks, such as those mentioned, should not be considered in scoring this item.

**Q: If a patient can perform most of the bathing task (i.e., can wash most of his/her body) in the shower or tub, using only devices, but needs help to reach a place, would the score be "1" because he/she is independent with devices with a "*majority*" of bathing tasks?**

**A:** The correct response is "2" – "able to bathe in the shower or tub with the assistance of another person:" c) for washing difficult to reach areas", because that response describes that patient's ability at that time. (You should record the patient's ability on the day of the assessment and if the patient's ability varies (on that day), the clinician should choose the response that describes the patient's ability more than 50% of the time **(not the patient's ability to perform more than 50% of the tasks).**

**Q: For patients whose regular habit is to sponge bathe themselves what should be marked for MO670?**

**A:** The patient who regularly bathes at the sink or lavatory must be assessed in relation to his/her **ability** to bathe in the tub or shower. What assistance would be needed for the patient to be able to bathe in the tub or shower? For example, if it is determined that the patient would be able to shower or bathe in the tub if stand-by assistance of another person was always available, response "2" would be marked.

**Q: Given the following situations what would be the appropriate responses to MO670?**

- **The patient's tub or shower is nonfunctioning or is not safe for use:** The patient's environment can impact ability to complete specific ADL tasks. If the tub or shower is nonfunctioning or not safe for use, then the patient is currently unable to use the facilities. Response 4 or 5 would apply, depending on the patient's ability to participate in bathing activities outside the tub/shower.
- **The patient is on physician-ordered bed rest:** The patient's medical restrictions mean that the patient is unable to bathe in the tub or shower at this time. Response 4 or 5, whichever most closely describes the patient's ability at the time of the assessment.
- **The patient fell getting out of the shower on two previous occasions and is now afraid and unwilling to try again:** If the patient's fear is a realistic barrier to her ability to get in/out of the shower safely, then she is unable to bathe in the tub/shower. If she refuses to enter the shower even with another person present, either response 4 or 5 would apply, depending on the patient's ability at the time of assessment. If she is able to bathe in the shower when another person is present, then response 3 would describe her ability.
- **The patient chooses not to navigate the stairs to the tub/shower:** Must consider the patient's environment when responding to the OASIS items. If the patient chooses not to navigate the stairs, but is able to do so with supervision, then her ability to bathe in the tub or shower is dependent on that supervision to allow her to get to the tub or shower. While this may appear to penalize the patient whose tub or shower is on another floor, it is within this same environment that improvement or decline in the specific ability will subsequently be measured.

***MO680- Toileting: Ability to safely get to and from the toilet or bedside commode. (Excludes personal hygiene & management of clothing when toileting)***

***0-Able to get to and from the toilet independently with or without a device***

***1-When reminded assisted, or supervised by another person, able to get to and from the toilet.***

***2-<u>Unable</u> to get to and from the toilet but is able to use a bedside commode (with or without assistance)***

***3-<u>Unable</u> to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently***

***4-Is totally dependent in toileting***

**Q: In MO680, if a patient is unable to get to the toilet or bedside commode, and uses a bedpan what score would apply if the pt were able to safely and independently complete all tasks except removing and emptying the bedpan/urinal?**

**A:** The patient does not need to empty the bedpan or urinal to be considered independent. If the pt required assistance to use the bedpan/urinal (i.e., get on or off the bedpan or position the urinal), he/she would not be considered independent and response "4" would be the best response. If the pt could position the urinal or get on/off the bedpan independently, response "3" would be appropriate.

**Q: If the patient has urinary catheter, does this mean he is totally dependent in toileting?**

A: MO680 does not differentiate between pts who have urinary catheters and those who do not. The item simply asks about the pt's ability to get to and from the toilet or bedside commode. This ability can be assessed whether or not the pt uses the toilet for urinary elimination.

**Q: If the patient can safely get to and from the toilet independently during the day, but uses a bedside commode independently at night, what is the right response?**

**A:** If the patient *chooses* to use the commode at night (possibly for convenience reasons), but is *able* to get to the bathroom, then response "0" would be appropriate.

***MO690- Transferring: Ability to safely move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast.***

***0-Able to independently transfer***
***1-Transfers with minimal human assistance or with use of an assistive device***
***2-<u>Unable</u> to transfer self but is able to bear weight <u>and</u> pivot during the transfer process.***
***3-Unable to transfer self and is <u>unable</u> to bear weight <u>or</u> pivot when transferred by another person.***
***4-<u>Bedfast</u>, unable to transfer but is able to turn and position self in bed.***
***5-<u>Bedfast</u>, unable to transfer and is <u>unable</u> to turn and position self.***

**Q: My patient must be lifted from the bed to a chair. He cannot turn himself in bed & is unable to bear weight or pivot. How would I respond to MO690?**

**A:** Response "3" is the option that most closely resembles the patient's circumstance. The pt is unable to transfer and is unable to bear weight or pivot when transferred by another person. Because he transfers to a chair he wouldn't be considered bedfast. Even though he cannot help with the transfer. Responses "4" and "5" do not apply for the patient who is not bedfast.

**Q: If other types of transfers are being assessed (e.g., car transfers, floor transfers), should they be considered when responding to this MOO item?**

**A:** Because standardized data are required, only the specific transfer tasks listed in MO690 should be considered. Based on the patient's unique needs, home environment, etc., transfer assessment beyond bed to chair, toilet/commode or tub/shower transfers may be indicated. Note in the patient's record the specific circumstances and patient's ability to accomplish other types of transfers.

**Q: If a patient takes extra time and pushes up with both arms, is this considered using an assistive device?**

**A:** "Pushing up with both arms" could apply to two of the transfer types – bed to chair and on/off toilet or commode. Taking extra time and pushing up with both arms can help ensure the patient's stability and safety during the transfer process but does not mean that the patient is not independent. If stand-by human assistance is necessary to assure safety, then a different response level would apply to these types of transfers. **Remember that transfer ability can vary across these three activities. The level of ability applicable to the majority of the activities should be recorded.**

***MO700- Ambulation/Locomotion: Ability to <u>SAFELY</u> walk, once in a standing position, or use a wheelchair, once in a seated* position, *on a variety of surfaces.***

***0-Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e., needs no human assistance or assistive device)***

***1-Requires use of a device (e.g., cane, walker) to walk alone <u>or</u> requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.***

***2-Able to walk only with the supervision or assistance of another person at all time.***

***3- Chair-fast, <u>unable</u> to ambulate but is able to wheel self independently.***

***4- Chair-fast, unable to ambulate and is <u>unable</u> to wheel self.***

***5- Bed-fast, unable to ambulate or be up in a chair.***

**Q: If a patient uses a w/c for 75% of their mobility, and walks for 25% of their mobility, then should they be scored based on their w/c status because that is their mode of mobility > 50% of the time? Or should they be scored based on their ambulatory status, because they do not fit the definition of "chair-fast"?**

**A:** Item MO700 addresses the patient's ability to ambulate, so that is where the clinician's focus must be. Endurance is not included in this item. The clinician must determine the level of assistance needed for the patient to ambulate and choose response "0", "1" or "2", whichever is the most appropriate.

**Q: What if the patient has physician ordered activity restrictions due to a joint replacement? What they are able to do and what they are ALLOWED to do are two different things. How to respond?**

A: The patient's medical restrictions must be considered in responding to this item, as the restrictions address what the patient is able to safely accomplish at the time of the assessment.

**Q: Does MO700 include the ability to use a powered w/c or only a manual one?**

**A:** This OASIS item does not differentiate between the ability to use a powered wheelchair or a manual one.

***MO780- Management of Oral Medications: <u>Patient's ability</u> to prepare and take all prescribed <u>oral</u> medications reliably and safely, including administration of the correct dosage at the appropriate time/intervals. <u>Excludes</u> injectable and IV medication. (Note: this refers to ability, not compliance or willingness). (If patient's ability to manage medications varies from medicine to medicine, consider total daily doses in determining what is true MOST of the time.)***

***0-Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.***
***1-Able to take medication(s) at the correct times if: (a)individual dosages are prepared in advance by another person; <u>OR</u> (b) given daily reminders; <u>OR</u> (c) someone develops a drug diary or chart.***
***2-<u>Unable</u> to take medication unless administered by someone else***
***3-No oral medications prescribed.***

**Q: For a patient who is independent with all medications except one, which has to be administered b someone else, would the correct response be "1"?**

**A:** The clinician must determine the total number of daily doses involved to determine what is true most of the time. For example, a patient had two medications, one of which was taken daily and one of which was taken 4-6 times a day, and was independent with taking both medications the first time in the morning, but needed reminders to take the remaining 3-5 doses of the second medication. The correct response would be "1".

**Q: When answering MO780 should medication management tasks related to filling and reordering/obtaining the medicine be considered?**

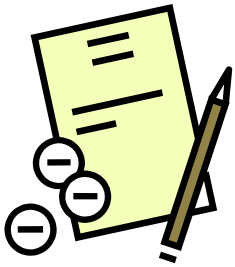
**A:** NO.

**Q: Should assessment include only prescription medicines? Or should over-the-counter oral medications be included as well?**

**A:** Scoring of MO780 should include all oral medications, prescribed and non-prescribed, that the patient is currently taking.

**Q: My patient sets up her own pill planner. How would I answer MO780?**

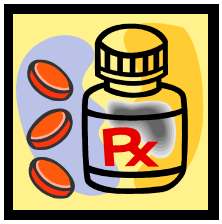
**A:** If your patient is able to take the correct medication in the correct dosage at the correct time as a result of this set up, then you would consider her independent and response "0" would apply. If your patient relies on a list of medications created by another person to set up her pill planner, response "1" would be more appropriate. If the patient follows a list that she made herself, she is independent and response "0" would apply.



**Q: If my patient uses a list of medications to self-administer medicines would this be considered a drug diary or chart?**

**A:** Yes. The statement for response 1 (c) ("someone develops a drug diary or chart) pertains to anyone developing the aid. What you need to assess is whether the patient must use this list to take the medications at the correct times. If he/she does require the list, then response "1" is the appropriate choice.

**Q: How would you answer if the patient lives in an assisted living where they require staff to give the medications and the patient appears able to take oral medications independently?**




**A:** MO780 refers to the patient's ability to take the correct oral medications and proper dosages at the correct times. Your assessment of the patient's vision, strength and manual dexterity in the hands and fingers as well as cognitive ability will allow you to evaluate this ability, despite the facility's requirement. (You would certainly want to document the requirement in the clinical record).

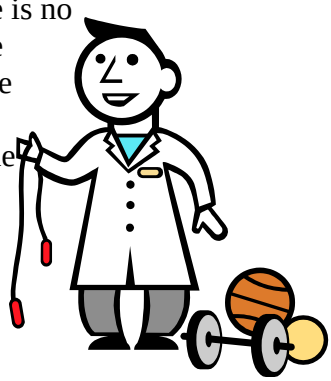
***MO825- Therapy Need: Does the care plan of the Medicare payment period for which this assessment will define a case mix group indicate a need for therapy (physical, occupational, or speech therapy) that meets the threshold for a Medicare high-therapy case mix group?***

***0 – No ( if no therapy services are needed or if the intensity of therapy services does not meet the threshold for Medicare high-therapy use.)***
***1 – Yes (if the therapy services meet {or exceed} the threshold)***
***NA – Not applicable (Will always be checked if the patient is non-PPS)***

**Q: What are the HHA's options if they originally answered "no" to MO825 but subsequently performed 10 or more PT visits? What if the HHA answered "yes" to MO825 but performed less than 10 PT visits over the course of the episode?**

**A:** If the therapy need was ***under-estimated*** at the beginning of the episode, and there is no clinical change in the patient's health status, the HHA may cancel the original RAP and resubmit it. The HHA should make a note in the patient's record as to the difference between therapy originally estimated and the therapy actually delivered and correct the original assessment at MO825 (i.e., change the NO to a Yes) that will update the HHRG. Agencies can make this non-key field change to their files and retransmit the corrected assessment. HHAs should refer to the correction policy found on the OASIS website at **http://www.cms.hhs.gov/oasis/datasubm.asp**.

If the therapy need was ***over-estimated*** at the beginning of the episode and there is no clinical change in the patient's health status, the HHA should make a note in the patient's record as to the difference between therapy originally estimated and the therapy actually delivered. However, it is not necessary to correct the original assessment at MO825 to update the HHRG. The HHA's payment for the episode



will automatically be adjusted to reflect that the therapy threshold was not met. If there is an unexpected change in the patient's clinical condition due to a major decline or improvement in health status that warrants a change in plan of treatment, an Other F?U Assessment (RFA #5) is expected to document the change. This is in keeping with the regulation at 42CFR 484.55(d), Update of the Comprehensive Assessment, and 484.20(b), Accuracy of Encoded data. The OASIS assessment must accurately reflect the patient's status at the time of the assessment. For payment purposes, the RFA 5 is the basis for the SCIC adjustment when no hospitalization is involved. It is necessary to have one consistent document for the patient's assessment, so if therapy visits are increased there should be concurrent OASIS and clinical record.

**Q: What if @ SOC MO825 was answered "yes" but then the patient was hospitalized in the middle of the episode and when they came home they were to continue the therapy? How do you answer MO825 in the ROC assessment since you would not get 10 or more visits in from the time of ROC to the end of the episode?**

**A:** An agency must think of the ***WHOLE*** episode of care. When a patient returns from the hospital: If "yes" was answered at SOC then "yes" would be answered at ROC. The threshold pertains to the whole episode not amount of time left after the ROC. If a patient at SOC does not have therapy and MO825 is answered "no" and they go into the hospital and are discharged with PT but cannot meet the threshold before the end of the episode then MO825 would be answered "no". If the threshold could be met after discharge then MO825 would be answered "yes".
***AT ROC MO825 MUST ALWAYS BE ANSWERED "YES" OR "NO" OR A HIPPS CODE WILL NOT BE GENERATED. "NA" will always be checked if a patient is a NON-PPS patient.***

**Q: When answering MO690 if your patient using the arms on his/her chair to help get up would this be considered using assistive devices? How about if they have a raised toilet seat?**

**A:** Using the arms on a chair to assist with getting out of the chair are not considered using assistive devices. A raised toilet seat, however, is considered an assistive device.

***MO830- Emergent Care: Since the last time OASIS data were collected, has the patient utilized any of the following services for emergent care (other than home care agency services)? (MARK ALL THAT APPLY)***

***0-No emergent care services***
***1-Hospital emergency room (includes 23-hour holding)***
***2-Doctor's office emergency visit/house call***
***3-Outpatient department/clinic emergency (includes urgicenter sites)***
***UK- Unknown***

***MO840- Emergent Care Reason: For what reason(s) did the patient/family seek emergent care? (MARK ALL THAT APPLY)***

***1-Improper medications administration, medication side effects, toxicity, anaphylaxis***
***2-Nausea, dehydration, malnutrition, constipation, impaction***
***3-Injury caused by fall or accident at home***
***4-Respiratory problems***
***5-Wound infection, deteriorating wound status, new lesion/ulcer***
***6-cardiac problems***
***7-Hypo/Hperglycemia, diabetes out of control***
***8-Gi bleeding, obstruction***
***9-Other than above reasons***
***10-Reason unknown***


**Q: If a patient receives portable X-rays in their home/place of residence after a fall, is this considered emergent care? What response at MO830 is selected?**

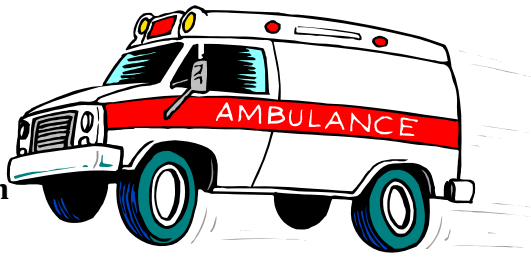
**A:** YES, this would be considered emergent care and should be reported as such on MO830. (If the service was not provided by any of the entities listed, but as a contracted service, then MO830 should be scored based on who ordered the x-ray).

**Q: If a patient receives a home visit from a nurse practitioner from the doctor's office in response to a fall, or increased pain, or other problematic symptoms, would this be considered emergent care?**

**A:** YES, the (non-home care) nurse's home visit would be considered emergent care, and would be reported based on the entity (hospital, doctor's office, OP clinic) that sent the nurse.

**Q: If a patient goes for emergent care and is then admitted to the hospital, what is the appropriate response to MO830?**

**A:** Current events must be included in the response to this item. Therefore, the patient who goes for emergent care and is admitted to the hospital did receive emergent care. The appropriate response to MO830 would be "1", "2", or "3", depending on where the patient received the emergent care.




**Q: What if the patient is a direct admit but never went through the ER?**

**A:** If a patient is admitted to the hospital ***DIRECTLY*** for emergent reasons then "0" – no emergent care services, would be answered (providing that was the only event.)

**Q: The patient was held in the ER suite for observation for 36hrs. Was this a hospital admission or emergent care?**

**A:** If the patient was never admitted to the IP facility, this encounter would be considered *emergent care.* The time period that a patient can be "held" without admission can vary from location to location, so the clinician will want to verify that the patient was never actually admitted to the hospital.

***MO870- Discharge Disposition: Where is the patient after discharge from your agency? (Choose only ONE answer.)***

***1-Patient remained in the community (not in hospital, nursing home, or rehab facility) (This includes assisted living or board and care housing)***
***2-Patient transferred to a noninstitutional hospice (patient receiving hospice care at home or a caregiver's home)***
***3-Unknown because patient moved to a geographic location not served by this agency***
***UK-Other unknown***

**Q: My patient was admitted to the hospital, and I completed the assessment information for Transfer to the IP Facility. His family informed me that he will be going to a nursing home rather than returning home, so my agency will discharge him. How should I complete MO870 on the discharge assessment?**

**A:** Once the transfer information was completed for this patient, no additional OASIS data would be required. Your agency will complete a discharge summary that reports what happened to the patient for the agency clinical record. *(The principle that applies to this situation is that the patient has not been under the care of your agency since the IP facility admission. Because the agency has not had responsibility for the patient, no additional assessments or OASIS data are necessary.)*

**Q: How do you answer MO870 if my patient is being discharged from a payer source in order to begin care under a new payer source?**

**A:** The OASIS items do not request a reason for discharge, only whether the patient is continuing to receive services if he/she remains in the community. In this situation, the appropriate response for MO870 would be "1" – patient remained in the community, and the correct response for MO880 would be "3" – Yes, assistance or services provided by other community resources.

***MO903-Date of Last (Most Recent) Home Visit:***
***Month/day/year***

**Q: Do the dates in MO903 & MOO90 always need to be the same? What situations might cause them to differ?**

**A:** When a patient is discharged from the agency with goals met, the day of the assessment (MOO90) and the date of the last home visit (MO903), are likely to be the same. Under three situations these dates are likely to be different: (1) transfer to an IP facility; (2) patient death at home, and (3) the situation of an "unexpected discharge. In these situations, the MOO90 date is the date the agency ***learns*** of the event, which is not necessarily associated with a home visit. MO903 must be the date of an actual home visit.

**Q: My patient died at home 12/1 after the last visit of 11/30. I did not learn of her death until 12/4. How do I complete MO903 & MO906? What about MOO90?**

**A:** You will complete an agency discharge for the reason of death at home (RFA 8 for MO100). MOO90 would be 12/4 – the date you learned of her death. MO903 (date of last home visit) would be 11/30, and MO906 (death date) would be 12/1.

***MO906-Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient***
***Month/day/year***

**Q: How do you deal with "unplanned or unexpected" discharges? Using these dates (SNV done 8/4; Aide visit 8/5 & 8/7):**

- **How would you complete the OASIS if the physician calls the agency & discharges the patient on 8/8? What dates are used for MOO90, M)903 & MO906?** All OASIS data required for discharge must be reported. MO100-Reason Assessment is Being Completed will indicate that the patient is being discharged from the agency, but NOT to an IP facility. **MOO90** would be noted as 8/8, the date the agency learns of the discharge (this is the date to be used for compliance with the encoding and locking period). **MO903**-Date of Last (Most Recent) Home Visit would be noted as 8/7. **MO906**-Discharge/Transfer/Death Date would be reported as 8/8. (To be compliant with the discharge comprehensive assessment requirement, the qualified clinician that last saw the patient should complete the agency's discharge documentation as completely as possible, based on the patient status at that provider's last visit – in this example, 8/4. The clinician should note on this documentation that it is "based on the visit of mm/dd/yyyy." The OASIS data from this assessment will be encoded, locked, and transmitted. The agency will thus have a discharge assessment recorded and a clinical record document that matches the OASIS data transmitted to the State.

- **What if the same dates apply but there are no aide visits?** The date recorded in MO903 – Date of Last (Most Recent) Home Visit would be 8/4, the date of the nurse's visit.
- **What if the SNV on 8/4 was a SOC followed by the aide visits on 8/5 & 8/7?** The HHA must report the patient's status from an actual visit – in this case, the only possible visit would be the SOC assessment. The qualified clinician must complete the agency's discharge documentation with a note that the assessment is based on the visit of mm/dd/yyyy.
- **What if the nurse makes the visit on 8/4, expecting this to be the discharge visit pending a final check with the patient a few days later and a telephone call to the patient on 8/8 confirms the patient is doing well, and the agency discharges the patient?** Because the nurse is expecting the discharge to occur, it is recommended that a complete assessment be recorded on 8/4. However, the regulations will require an assessment congruent with the discharge date of 8/8. The agency must assure the presence in the clinical record of a discharge assessment completed on (or within 48hrs of) the date recorded in MOO90 (8/8 in this example). The HHA has two options: (1) conduct a (most likely non-reimbursable) visit on or after 8/8 to complete another discharge assessment, or (2) to follow the procedures for recording a discharge assessment dated 8/8, based on the patient status of 8/4 (and so noted in the clinical documentation). Possible a better option would be to place the telephone call to the patient within 48hrs of the 8/4 visit, thus placing the discharge assessment and the discharge date within 48hrs of each other.

HHA'S MUST BE AWARE THAT RETROSPEDCTIVE DATA REPORTING CAN NEGATIVELY IMPACT THE AGENCY'S OUTCOME REPORT IN 2 WAYS: (1) THE CLINICIAN'S RECALL OF PATIENT STATUS INFORMATION IS LIKELY TO BE LESS ACCURATE THAN THE INFORMATION RECORDED IMMEDIATELY UPON ASSESSMENT, AND (2) THE PATIENT'S STATUS AT THE TIME OF DISCHARGE MAY ACTUALLY BE BETTER (I.E., IMPROVED) THAN IT WAS AT THE TIME OF THE VISIT CONDUCTED BY THE RN, PT, SLP, OR OT.